DOCUMENT RESUME

ED 204 875 EC 133 342

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TITLE Simple Justice: A Case for Mainstreaming the Severely Emotionally Handicapped Bilingual Preschool Child.
PUB DATE Feb 81
NOTE 9p.; Paper presented at The Council for Exceptional Children Conference on The Exceptional Bilingual Child (New Orleans, LA, February, 1981, Session Th-29).

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Community Programs; *Emotional Disturbances; Intervention; Mainstreaming; *Mental Health Programs; *Mexican Americans; *Parent Participation; *Preschool Education; Program Descriptions; *Program Development

ABSTRACT

The paper deals with a mental health program designed to treat the 2 1/2 to 5 year old Mexican American child with severe emotional or behavioral problems. Components of the program included a mutual agreement with Parent Child Centers (Headstart) in the community; staff who had expertise to evaluate, diagnose, design, and implement an individual treatment plan for each child coming into the program; involvement of the home (parent, sibling, family); and assistance for the child and his/her family in the transition to a new school and social environment. (SB)

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Simple Justice: A Case for Mainstreaming the Severely Emotionally Handicapped Bilingual Preschool Child.

Stephania O'Neill and Linda Levy

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This paper is about young children. Young children who are economically poor. Young children who are experiencing severe emotional problems. These children and their families live in an area which has the highest unemployment rate, the lowest level of educational attainment, the highest proportion of welfare recipients, and the largest percentage of families living in crowded conditions in Pima County, Arizona. This area, referred to as Pima South, also has the highest concentration of minorities (51%) of any community mental health catchment area within the state of Arizona. Forty-one (41) per cent are Mexican American. La Frontera is the community mental health center serving this area.

After La Frontera's establishment in 1969, it became apparent from referrals which were received from parents, child protective services, the Department of Economic Security, Well-Baby Clinics, Public Health Agencies, and Day Care Centers, that there was a need for a program for the very young child and his/her family. The types of emotional and behavioral problems being referred were of the mild type such as toddler temper tantrums to the more severe types such as extreme withdrawing behavior, or extreme unsocialized aggressive behavior. It became clear that there was a program needed which would develop sound treatment modalities to deal with the minor difficulties being experienced, as well as the more severe problems being manifested, by the young child. It was also clinically sound to begin to design a program for the very young child based upon the research substantiating the need for and value of primary and secondary prevention in the field of mental health. This presentation will deal with the component of the program designed to treat the child (aged 2½ to 5 years of age) demonstrating severe emotional or behavioral problems.

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The challenge was to design a program tailored to the families living in this community; a large percentage being children of Mexican American heritage who were monolingual Spanish speaking or bilingual with their primary language being Spanish.

So the work began. It was decided that the program would be based on the philosophy

that the early years of life are most critical in forming an opinion of him/herself. That a child's self concept cannot be separated from his culture or his language. The importance of one's early self concept influences to what extent a child becomes mentally healthy and maintains through his/her life sound mental health. It was also perceived that any program designed to help these children and their families must focus around the belief that the entire environmental milieu determines to what extent a child will develop to potential. It was recognized that the home (parent/sibling/family) relations and the community (neighborhood, school) are the basis for this milieu. Therapeutic intervention, when appropriate, should then consider and use as its basis all the child's experiences, (culture, economics, language, etc.) in any treatment plan designed for these children. With this philosophical base, we designed a program taking into consideration this entire milieu. We decided the treatment program must involve a preschool experience. We were committed to the belief that the treatment of the child would have to take place in a school setting which:

1. Was culturally responsive and culturally comfortable,
2. Had a bilingual program and a bilingual staff,
3. Was a part of the child's community,
4. Had a curriculum that met the higher quality demanded by a good early childhood program,
5. Was concerned with the total development of the child in all areas,
6. Would be willing to accept and mainstream children having severe emotional and/or behavioral difficulties,
7. Would have a strong family involvement component to help the family and child develop a natural eco-structural support system within their own community.

This first challenge was met by putting together a mutual agreement with the Parent Child Centers (Headstart) in our community. It was a mutual agreement which was beneficial to both agencies. We were able to obtain four classrooms where we were able to place three to four children in need of therapeutic services. This enabled us to meet our preceding criteria. The Headstart Preschool, in which La Frontera has its four classrooms, is located within the boundaries known as our catchment area. In this way we were able to work with

our children in their own community rather than transporting the children to distant locations where our children and their families may be uncomfortable. Based upon our concept of family involvement as a system of support, we surmized that due to an initial separation from the family (especially the mother) and experiencing an alien environment and a new set of authoritarian figures, the first few days in the new preschool setting might be painful. These changes can be a source of great stress. For the emotionally distressed child who either speaks no English, or has no proficiency in Spanish or English, there can be additional trauma and culture shock. It was our belief that we had found in the Headstart Program a committment to bilingualism necessary to the mental well-being of our children as well as a keen understanding and acceptance of the importance of kinship and family in Mexican American families.

Of course, having a good classroom was not enough. We had to set up our own staff. A staff who had the expertise to evaluate, diagnose, design and implement an individual treatment plan for each child coming into the program. The staff had to possess the background necessary to meet the needs of the children. It is necessary for our staff to have an awareness of sociocultural elements which will determine the success or failure of the classroom experiences and the child's progress in regard to mental health.

Because the preschool would be in most cases the first experience away from home and family, it was essential that the La Frontera staff have a knowledge of the cultural implications in order to make a consistent effort to correlate treatment with the child's ethnicity. We needed staff who knew that traditionally in the Mexican American family there seems to be clear definition of appropriate behavior for children and special regard for respect of parents and elders. These expectations of children with regard to good vs. bad behavior are similar to the religious doctrines of the Catholic Church. This code of behavior is positively expressed in the term discipline and negatively expressed in the term "malcriado" which applies to one who misbehaves.

Following are contrasting values of the Mexican American and Anglo American worlds which needed to be known by our staff in order to establish a meaningful individualized treatment plan.

Mexican American World	Anglo American World
Cooperation	Competition
Politeness, courtesy	Frankness
Obedience	Domination
Respect for Authority	Defensiveness of it
Authority of the Father and Obligation of the Mother	Shared Authority Between Parents
Children as Subordinate Family Members	Children Independent of Family Members
Close Family Ties	Independence of the Family Unit

With this as an important foundation, we organized our staff. It is made up of a Preschool Supervisor, required to have an appropriate Masters Degree, a Medical Director who is a Child Psychiatrist, and four Child Family Specialists required to have A.A. Degrees and/or experience. The essential considerations in hiring staff would be:

1. An expertise in dealing with young children and their families. An expertise based upon education and experience.
2. Staff being bilingual and/or bicultural and/or having a knowledge and sensitivity to the cultural and language implications of the community.

To demonstrate how this has been achieved, currently our staff of six is made up of all members who have had experience working with Mexican American children and their families. All have had experience with young children and special-needs children. Currently there are four staff members who are bilingual, two of whom are bilingual and bicultural.

Evaluation, diagnosis, design and implementation of treatment is done by a team approach. The Preschool Supervisor begins the progress by the initial interview with the parents and a playroom session with the child. If the Preschool Supervisor perceives the child of needing the program, a psychiatric evaluation is scheduled. The Child Family Specialist visits the home and submits a report. At the staffing, all are involved and after a consultation, the child, if appropriate, is placed in the program. The Child

Family Specialist becomes the case manager, and with the supervision of the Preschool Supervisor and the Child Psychiatrist, coupled with input from the family, developes a treatment plan for the child and his family. It is the Child Family Specialist who directly implements the treatment plan with the child and the family. The Special Needs Coordinator of Headstart is informed; the necessary Headstart papers are filled out and the child and family are phased into the program.

We now had the school component of the program, and the staff that would work with the child in the school. Our next challenge was how to best involve the home (parent, sibling, family). It was decided that there would be a great deal of emphasis placed upon this aspect of treatment. This was a sound judgment based upon the literature dealing with intervention in the lives of preschool children. What was the best way to involve the entire home environment? Should we set up parent groups? Should we set up weekly meetings at the Clinic? It was decided, based upon the literature in the field, and our knowledge of our community, that the best place to begin intervening with the family was on their own familiar turf. The home was the place that would be most comfortable to both the child and the family. As a result of this perception, weekly home visits became a required component of the program. During these weekly sessions, the Child Family Specialist could help the family by modeling parenting skills; could involve all the members of the family in the program by discussions and demonstrating appropriate activities which would be helpful to the child, etc.

As a final component of the program, when a child is either of age to leave our program, or emotionally stable enough to leave, we assist the child and his/her family in the transition to a new school and social environment. It may be the first time this family has had to deal with an academic setting which doesn't offer bilingual facilitation in deciding what type of classroom will best meet the needs of the child and the family. The placement process includes a staffing which gathers numerous professional recommendations, coupled with those of the parents, in an effort to assure both the child and the family the least amount of emotional stress. Once the teacher, the parents, and children

have become acquainted, we follow this family indefinitely by staying in touch with the school social worker in an effort to offer the most comprehensive followup service available.

We have described a program designed specifically for young children; young children who are Mexican American; Young children who are experiencing severe emotional difficulties. This program was started considering as its basis for design, the type of child to be served. It was designed in such a way that in order to heal the emotionally problemed child, we would in no way add to the stress and confusion by rejecting what the child was or his/her heritage. The treatment would take place in a setting where the child could belong; where it was acceptable to be called Tomás, Miguel; where they could be a part of the group singing "Buenos Días", "Buenos Días"; where they were not made to feel different.

Yet at the same time, Tomás and Miguel would be learning a new language, English, which would help them rather than become a source of stress and shock as they become a part of the public school system and a predominantly Anglo-English speaking society.

The final question to be dealt with is, does the program work? We believe it does. The best proof is the involvement of the Mexican American community. Our enrollment has always included at least 50% Mexican American children, which more than reflects the percent in the community. Approximately 75% of our children enter into regular kindergarten programs. It is not a perfect program and we are always looking for ways to improve our services. But we do feel we have accomplished the simple justice of matching services directly to the unique needs of our Mexican American children and their families.

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